STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Lutheran Home	1405 7th Street South Moorhead, MN 56560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report an incident of neglect of care with serious bodily injury was reported within 2 hours of the State Agency (SA) for 1 of 1 residents (R1) who fell out of bed and sustained a fractured clavicle along with a laceration when staff were not following the care plan.Findings include:R1's annual minimum data set (MDS) dated [DATE], identified R1 was cognitively intact. and was dependent on staff for toileting, bed mobility, and transferring. R1 had anxiety, pain and a history of falls with fractures.R1's care plan revised 6/13/26, identified R1 had a potential for falls related to decreased mobility, a history of falls, and weakness. R1 was alert and orientated to person, place and time. R1's care planned interventions included low bed with fall mat to the floor when R1 was in bed and soft touch call light at the hip to promote use.R1's fall risk predictive factors assessment dated [DATE], indicated R1 had poor recall, judgment, and safety awareness. It further indicated that R1 had poor vision status and a history of three or more falls in the past three months.R1s care sheet undated, indicated R1 was a fall risk and was to have low bed and floor mat along with soft touch call light to right hip.R1's incident report dated 6/12/26 at 4:45p.m., identified the nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. I was determined based on the scene where R1 had raised her bed in a high position and attempted to self-transfer. R1s call light was in the chair next to the bed. R1 has a history of falls. R1 used her bed controller to put the bed up approximately four feet. NA-A confirmed she had the bed in low position but did not have the fall mat next to the bed. R1 was assessed for injuries. R1 was transferred into her bed with a hoyer sling lift. Medical provider notified of all and head injury. Medical provider ordered R1 to be sent to the ED for evaluation and treatment. R1s spouse was notified of the injury.Progress notes on 6/12/26 at 6:21 p.m., time of fall 4:39 p.m. nurse was alerted via walkie talkie that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. R1 was drowsy when first checked, R1 awakened when assessed, R1 had a head laceration somewhere behind her right ear on the scalp which she was bleeding from. R1 assisted into bed with hoyer sling lift and two person assist. Care plan updated to keep bed controls turned off by removing the remote. R1 was unable to control the bed functions safely. Medical doctor notified at 4:50 p.m. Spouse notified at 5:15 p.m.Progress notes on 6/12/26 at 11:16 p.m., R1 returned from the hospital around 9:30 p.m. Closed displaced fracture of acromial end of right clavicle. Laceration of scalp. R1 has a sling on right hand. CT of head without contrast was done. CT spine cervical without contrast. R1 has been (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleeping throughout the night. No complaints of shortness of breath (SOB), no complaints at this time.Incident report received at SA on 6/13/26 at 9:18 a.m.During a phone interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-C indicated R1 had fallen prior to RN-C's shift. RN-C stated when RN-C arrived for RN-C's shift R1 was currently at the hospital. RN-C indicated RN-C did not receive a call from the emergency department (ED) prior to R1 returning to the facility. RN-C further indicated R1 was transported back from the ED by R1's spouse on 6/12/26, around 9:30 p.m. RN-C stated RN-C indicated RN-C was made aware R1 had a clavicle fracture. RN-C further indicated RN-C thought the manager knew about the facture, so RN-C did not call the on-call manager when R1 arrived back at the facility. RN-C indicated RN-C put a progress note in R1's electronic medical record (EMR) after RN-C completed R1's return assessment. RN-C stated RN-C shared in morning report that R1 had sustained a clavicle fracture.During a phone interview on 6/25/26 ,at 12:23 p.m., director of nursing (DON) verified R1 returned to the facility on 6/12/26. DON further indicated RN-C looked through R1's looked through her discharge paperwork and found R1 had sustained a clavicle fracture. DON stated RN-C had thought it had already been communicated so RN-C documented in R1's EMR and passed the information on during morning report. DON stated it was miscommunication. DON confirmed the report was filed the morning of 6/13/26, which was past the two-hour reporting requirements. DON stated it is important that reports are filed following the correct reporting requirements for residents' safety and also to ensure the facilities processes are on time correct. Review of a facility policy titled Vulnerable Adult- Minnesota dated 2/17/26, identified All staff, residents, and families are required to report suspected abuse or neglect of vulnerable adults. The DON or designee shall be responsible for maintaining a log of any suspected and/or actual cases of abuse orneglect. They shall verify that the report to the proper officials has been made and that appropriateintervention has been taken. Policy further identified, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries ofunknown source and misappropriation of resident property are to be reported: Immediately but not later than 2 hours after the allegation is made if the events that cause theallegation involve abuse or result in serious bodily injury.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide care consistent with a resident's needs and care plan to eliminate/reduce the risk of an accident in bed for 1 of 1 residents (R1). This resulted in actual harm to R1 when she rolled out of bed onto the floor. R1's fall mat was not alongside the bed and her call light was not within reach. As a result, R1 was transported to the emergency department (ED) on 6/12/26, for a laceration to the forehead and a fracture to her right clavicle. The facility had implemented actions to prevent recurrence prior to the survey on 6/23/26, therefore, the citation was issued at past non-compliance. Additionally, the facility failed to provide adequate supervision and secure transportation for R2 who has severe cognitive impairment.Findings include:R1R1's annual minimum data set (MDS) dated [DATE], identified R1 was cognitively intact. R1 was dependent on staff for toileting, bed mobility, and transferring. R1 had anxiety, pain and a history of falls with fractures.R1's care plan revised 6/13/26, identified R1 had a potential for falls related to decreased mobility, a history of falls, and weakness. R1 was alert and orientated to person, place and time. R1's care planned interventions included low bed with fall mat to the floor when R1 was in bed and soft touch call light at the hip to promote use.R1's fall risk predictive factors assessment dated [DATE], indicated R1 had poor recall, judgment, and safety awareness. It further indicated R1 had poor vision status and a history of three or more falls in the past three months.R1s care sheet undated, indicated R1 was a fall risk and was to have low bed and floor mat along with soft touch call light to right hip.R1's physical therapy treatment encounter dated 6/15/26, indicated R1 fell and was receiving skilled services to her right shoulder per providers orders.R1's incident report dated 6/12/26 at 4:45p.m., identified the nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. I was determined based on the scene that R1 had raised her bed in a high position and attempted to self-transfer. R1s call light was in the chair next to the bed. R1 has a history of falls. R1 used her bed controller to put the bed up approximately four feet. NA-A confirmed she had the bed in low position but did not have the fall mat next to the bed. R1 was assessed for injuries. R1 was transferred into her bed with a hoyer sling lift. Medical provider notified of all and head injury. Medical provider ordered R1 to be sent to the ED for evaluation and treatment. R1s spouse was notified of the injury.On 6/12/26, electromagnetic waves (X-ray) revealed R1 had an acute comminuted fracture of the lateral right clavicle, and it appeared somewhat impacted.On 6/12/26, computed tomography (CT) revealed R1 had a right lateral scalp hematoma.Provider Communication Forms revealed the following:-6/12/26, found on floor laying on right side, blood near head coming from laceration back of right ear. Was assisted back to bed, cleaned up. Called on-call medical provider, ordered to be sent in for evaluation and treatment. Returned from ED Friday evening. Has right clavicle fracture with sling. Staples to head laceration. Referral to orthopedics. Signed by primary provider 6/15/26.-6/15/26, immobilizer to right upper extremity (RUE) with Velcro at wrist ordered due to right clavicle fracture. Signed by primary provider 6/15/26.-6/15/26, discontinue physical therapy (PT) and speech therapy (ST). Signed by primary provider 6/15/26.-6/15/26, remove scalp staple on 6/20/26. Signed by provider 6/17/26.-6/16/26, R1 refused 2:00 p.m., dose of Tramadol (medication used for pain), then requested it at 4:00 p.m. Give one time only dose of Tramadol 50mg by mouth for pain. Wait four hours until next does. Signed by provider 6/16/26.[NAME] Internal Medicine Nursing Home APP visit dated 6/15/26, medical provider indicated the visit was related to a hospital discharge. R1 had a right clavicle fracture. R1 was to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wear an immobilizer to right upper extremity with Velcro at the wrist for six weeks. R1 will need to follow-up with orthopedics and plan to have a follow-up x-ray in two weeks. R1 had one suture placed and orders were given to remove the scalp staple on 6/20/26, eight days after placement.Progress notes dated 6/1/26 to 6/23/26 revealed the following:-6/3/26 at 10:25 a.m., R1 had her light on and requested help from staff. Staff helped R1 and left room.-6/11/26 at 2:15 p.m., R1 had her light on R1 requested to use the bathroom. R1 didn't need any additional assistance.-6/12/26 at 6:21 p.m., time of fall 4:39 p.m. nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. R1 was drowsy when first checked, R1 awakened when assessed, R1 had a head laceration somewhere behind her right ear on the scalp which she was bleeding from. R1 assisted into bed with hoyer sling lift and two person assist. Care plan updated to keep bed controls turned off by removing the remote. R1 was unable to control the bed functions safely. Medical doctor notified at 4:50 p.m. Spouse notified at 5:15 p.m.-6/12/26 at 6:38 p.m., R1 was transferred to [NAME] ED via emergency medical transport (EMT) due to fall and head injury. On-call provider notified and ordered transfer for evaluation and treatment at [NAME] ED. Supervisor and husband notified of R1's fall.-6/12/26 at 11:16 p.m., R1 returned from the hospital around 9:30 p.m. Closed displaced fracture of acromial end of right clavicle. Laceration of scalp. R1 has a sling on right hand. CT of head without contrast was done. CT spine cervical without contrast. R1 has been sleeping throughout the night. No complaints of shortness of breath (SOB), no complaints at this time.-6/14/26 at 4:47 p.m., writer completed a bed remote assessment with R1. Nursing delegated to client to complete raising and lowering head of bed, food of bed, and height of bed. Nursing delegated to client to complete putting bed at an appropriate height for transfer. Client was not able to complete any of these tasks safely. Will continue to keep bed remote out of reach of R1.-6/15/26 at 1:37 p.m., writer spoke with R1s spouse and daughter about intervention, and they consented to removing the bed remote for R1s safety.-6/15/26 at 3:46 p.m., elbow, wrist, hand range of motion three times a day. No weight bearing to right arm. Use right arm sling/immobilizer when up. Ok to remove for sleep and comfort.During an observation on 6/23/26 at10:50 a.m., R1 was laying in the bed watching television. R1's bed was in low position and fall mat was on the floor next to the bed. R1's call light was hooked to the railing of the bed. R1s legs were hanging off the edge of the bed. R1 had sling on right shoulder. R1 was unable to answer questions during an interview due to difficulties speaking. During an observation on 6/23/26 at 4:03 p.m., R1 was resting in the bed. R1 had removed the sling from right shoulder. R1s bed was in a low position and fall mat was on the floor. Call light was within reach. During an interview on 6/23/26 at 3:32 p.m., nursing assistance (NA)-A indicated NA-A had completed rounds and was helping another resident. NA-A heard over the walkie that R1 had fallen out of bed and was lying on the floor. NA-A indicated R1 had an open wound and there was blood on the floor. NA-A stated R1 had a history of using the remote to bring the bed up. NA-A further stated when NA-A entered the room R1's bed was in a very high position. NA-A confirmed NA-A had forgotten to place the fall mat next to R1's bed and R1's call light was in the chair. NA-A indicated NA-A received training on care plans and continued to work with co-workers completing walk through checklists of each resident's rooms to ensure safety. NA-A further indicated an all staff meeting was going to take place next month. During an interview on 6/23/26 at 3:40 p.m., medical provider (MP) indicated MP was aware of R1's fall and that R1 was treated in the ED. MP stated R1 sustained a fracture to R1's right clavicle and a laceration to R1's head. MP further stated MP had seen R1 for a follow up on 6/15/26. MP indicated R1 was to wear a sling and would be seen by orthopedics for a follow-up. MP stated she would expect staff to be following the care plan to prevent any accidents and keep residents safe. On 6/23/26 at 3:45 p.m., call made to registered nurse (RN)-A no answer and a voicemail was left. During (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	an interview on 6/23/26 at 4:10 p.m., licensed practical nurse (LPN)-A stated LPN-A was aware of R1's fall. LPN-A indicated LPN-A received education on care plans, falls, and working with NA's to ensure the safety checklists were being followed. LPN-A further indicated the safety checklists were used to ensure all care planned interventions were being followed for each resident. During an interview on 6/23/26 at 4:59 p.m., director of nursing (DON) stated she was aware of R1s fall and that R1 sustained injuries from the fall. DON confirmed R1's fall mat was not along side R1's bed and R1 did not have R1's call light within reach. DON indicated education was done with all staff working on the second floor immediately and shortly thereafter education was provided to all nursing staff. DON further indicated when NA-A returned for NA-A's next shift, NA-A worked with coworkers to complete safety checks on all residents on the second floor. DON stated when R1 returned staff removed R1's bed controller as an intervention for fall safety. DON stated her expectations were for staff to follow all care planned interventions to ensure resident safety. DON further stated care planned interventions were in place to protect the residents from harm.R2R2's quarterly MDS dated [DATE], identified R2 was severely cognitively impaired. R2 was dependent on staff for toileting, bed mobility, and transferring. R1 had Alzheimer's disease and dementia. R2's care plan revised 3/27/26, potential for safety concerns due to risk for elopement. R2s goal indicated R2 will not leave the facility unattended. Interventions in place were to check wander guard placement every shift and to identify triggers as R2 has a history of wandering the halls and using the elevator.R2's elopement risk assessment dated [DATE], indicated R2 was cognitively impaired with poor decision making skills and uses a wander guard.Progress notes dated 3/4/26, revealed R2 saw medical doctor at Essentia Dermatology, had cryotherapy completed to top of scalp and left ear. However, progress notes lacked documentation of the time R2 left the facility, when R2 returned to the facility and if R2 had an escort to R2's appointment. Review of a facility calendar dated 3/4/26, identified R2 had a scheduled ride to Essentia Health Dermatology by First-In Line Mobility with a pickup at 1:30 p.m., on 3/4/26 and a will-call return for transportation back to the facility once the appointment was completed.R2's electronic medical record (EMR) lacked documentation of paperwork sent with R2 for R2's dermatology appointment on 3/4/26.During an observation on 6/23/26 at 2:23 p.m., R2 was sitting in R2's wheelchair in the hallway next to the elevator. R2 had a blanket over R2's chest and R2 was moving back and forth. R2 had a wander guard on R2's right ankle. R2 was unable to answer any questions during the interview. During an observation on 6/23/26 at 4:07 p.m., R2 was sitting in the hallway near the nurses' station drinking a cup of coffee. R2 was moving around in R2's wheelchair. R2 had wander guard on right ankle. During an interview on 6/23/26 at 1:17 p.m., trained medical aid (TMA)-A indicated the NA's got resident's ready for appointments and would bring them to the nurses' station for pick-up. TMA-A stated the secretary was responsible for getting the resident's paperwork ready to take to appointments. TMA-A indicated that the transportation driver would come to the floor to pick the resident up. TMA-A stated if family was going to take the resident to an appointment, staff would bring the resident down to the front door. TMA-A was unsure if R2 required an escort to appointments or if any paperwork was sent to R2's dermatology appointment on 3/4/26.During an interview on 6/23/26 at 1:23 p.m., NA-B stated staff would take the resident up front to where their ride would pick them up. NA-B indicated they let the nurse and secretary know when the residents are ready for their appointments. NA-B indicated if the resident needed an escort the secretary would make sure they would have the escort before leaving the floor. NA-B stated there usually is an envelope at the desk that would go with the resident when they leave. NA-B was unsure if R2 required an escort to appointments or if any paperwork was sent to R2's dermatology appointment on 3/4/26. During an interview on 6/23/26 at 1:28 p.m., RN-B stated that staff just know if a resident required an escort for appointments. RN-B further stated at times, they will let us know if an escort was needed. RN-B indicated some residents who have wander guards can just go to appointments on their own. RN-B stated she was unaware if R2 required an escort for appointments or if an envelope was sent with R2 to his dermatology appointment of 3/4/26. RN-B further stated she was unaware of how R2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	returned to the facility after his appt on 3/4/26. During an interview on 6/23/26 at 1:30pm LPN-B indicated the secretary was responsible for setting up appointments. LPN-B further indicated rides are provided to residents based on their insurance. LPN-B stated envelopes are provided to the driver, resident or family with information about the resident and was returned to the facility when the resident arrived back. This paperwork was also used for the provider at the appointment to provide any updated orders. LPN-B further stated each envelope had a sticker at the top that provided a number for the provider to call when the appointment was finished for a return ride back to the facility. LPN-B indicated if a resident was not safe to go to the appointment alone family will be contacted for assistance or and escort would be provided. LPN-B stated determination was made on residents' safety if the resident required an escort. LPN-B further stated there really wasn't a process on the determination, they just know what residents are not safe to be out by themselves. LPN-B looked in R2's EMR and verified R2 had an appointment on 3/4/25 at 2:00 p.m. LPN-B indicated she was unaware R2 was brought back to the facility by the police department. LPN-B was unaware of what time R2 returned to the facility and did not know how long R2 had been gone. LPN-B confirmed LPN-B put a note in regarding R2's appointment but did not know how R2 arrived back at the facility from the appointment. LPN-B indicated R2's daughters would often attend R2's appointments but LPN-B could not confirm if R2's daughters were at the appointment on 3/4/26. LPN LPN-B confirmed R2 had a son but indicated LPN-B just met him for the first time a couple days ago. LPN-B was unsure if an envelope was sent with R2 to his dermatology appointment on 3/4/26. During an interview on 3/4/26 at 1:45 p.m., secretary stated R2 now has an escort for all appointments. Secretary indicated secretary was not in the current position when R2's appointment for 3/4/26 was scheduled. Secretary was unable to confirm if R2 had an escort for the appointment on 3/4/26. Secretary was unable to confirm when and how R2 returned to the facility or if an envelope for the receiving facility was sent with to R2's appointment at the dermatology clinic on 3/4/26.On 6/23/26 at 1:50 p.m., a call to R2's daughter was made and no answer. On 6/23/26 at 1:58 p.m. a call the Fargo Police Department (FPD) was made FPD indicated police reports could be found online by going to www.fargopolice.com. On 6/23/26 at 2:44 p.m., contacted the FPD through online database. 709 requested for police report. On 6/23/26 at 2:48 p.m., call to Nursing Supervisor Essentia Health and left a voicemail. During a phone interview on 6/23/26 at 2:49 p.m. first in line transportation supervisor (FILTS) confirmed R2 was picked up at 1:30 p.m., on 3/4/26. FILTS could not confirm if R2 had an escort or received a return ride to the facility from R2's appointment. FILTS stated envelopes are given to the receiving facility and the receiving facility calls the number when the residents appointment is finished. FILTS could not verify if R2 had an envelope for R2's appointment on 3/4/26. On 6/23/26 at 4:36 p.m., call to Essentia Health Dermatology, no answer.During an interview on 6/23/26 at 4:59 DON indicated DON did not feel there was anyway R2 could have been transported back to the facility by the police department. DON stated R2 was a hoyer lift and would have required the use of a lift to transfer R2. DON stated R2 used transportation to get to R2's appointments and family would generally meet R2 at the appointment. DON indicated family was supposed to meet R2 for his appointment on 3/4/26. DON stated R2's daughter was going to relay the appointment with R2's other daughter but had gotten the dates confused. DON confirmed R2 attended R2's appointment alone. DON stated that the resident returned to the facility as there was a note placed in R2's chart. DON could not confirm how or when R2 arrived back to the facility after R2's appointment. DON indicated the facility used an elopement assessment and that would be considered the safety assessment to ensure residents are or are not safe in the community alone. DON stated residents are never alone. DON further stated the transportation service picks the residents up and brings them to appointment. DON could not confirm if First In Line transportation service stayed with R2 for R2's appointment. DON stated the facility sends paperwork with each resident and that is to be handed off during the appointment and returned to the facility after the appointment. DON could not confirm if R2 had paperwork sent with R2 for R2's appointment on 3/4/26.On 6/24/26 at 7:35 a.m., (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	email received from FPD stating no police report containing R2's name was found for 3/4/26.During a phone interview on 6/24/26 at 8:02 a.m., Nursing supervisor Essentia Health (NSEH) stated nursing staff found R2 sitting alone in the lobby and brought R2 back to R2's appointment on 3/4/26. NSEH indicated FILT did not stay with R2 during his appointment. NSEH stated R2 did not have any documentation or paperwork with R2 from the facility providing any direction for nursing staff. Nursing staff were not aware R2 lived in a nursing home and had cognitive impairments. NSEH stated R2 told staff R2's son was going to pick R2 up after the appointment. NSEH indicated nursing staff assumed this was correct as R2 as R2 did not have any other information with R2. NSEH stated once the appointment was finished, staff brought R2 down to the pickup area for R2 to wait for his ride. HSEH stated nursing staff were not aware they needed to call FILT for a ride back to the facility for R2. HSEH further stated staff continued to check on R2 for approximately two hours in the pick-up area. NSEH indicated during this time, nursing staff attempted to contact R2's daughter but never received a call back. HSEH stated the last time nursing staff went to check on R2, R2 was no longer sitting in the pick-up area so nursing staff assumed R2's son picked R2 up. HSEH indicated on the morning of 3/5/26 the department received a telephone message from 3/4/26 from Eventide. HSEH stated the message was requesting information about R2's appointment. HSEH further stated nursing staff called Eventide back and spoke with LPN-B. HSEH indicated LPN-B stated R2 had been seen at the clinic on 3/4/26. HSEH stated nursing staff told LPN-B that R2 did not come with any paperwork so NSEH were unaware res lived in a nursing home or that R2 did not have a return ride to the facility, LPN-B indicated there was a mix up with R2's daughters who were usually with R2 for appointments. HSEH stated nursing staff told LPN-B that R2 was picked up by R2's son and LPN-B indicated R2 did not have a son. HSEH further stated LPN-B told nursing staff that R2 had been brought back to the facility by the police department. HSEH indicated LPN-B apologized for the mix up and nursing staff faxed paperwork from the appointment to Eventide.The past noncompliance that began on 6/12/26. The deficient practice was corrected by 6/19/26, after the facility implemented a systemic plan. Verification of corrective action was confirmed and interviewed with facility staff and review of training documentation. The nursing assistant involved verified she was promptly re-educated on the importance of following the nursing assistant care sheets. Documentation showed the facility had developed, implemented, and completed a plan to ensure that any staff responsible for providing cares were trained. This was confirmed by review of training records and staff interview. Observation of care in bed observed and verified that staff were following the nursing assistant care sheets. Facility was able to demonstrate monitoring of the corrective action and sustained compliance.Facility Policy titled Care Plans dated 2/10/26, to develop a person-centered care plan in conjunction with the interdisciplinary team and resident/resident representative that reflects the actual care, condition and preferences of each resident. Any changes made to the comprehensive care plan will also be updated in the NAR/CNA care plan.Facility policy titled Falls - Resident dated 2/13/26, all resident will be assessed for fall risk and individualized interventions will be implemented as appropriate to minimized the all risk and reduce injury.Facility policy titled wander guard dated 2/17/26, a wander guard is used to minimize potential resident elopement.Facility policy titled resident medical appointments dated 2/17/26, to arrange a safe transport and escort procedure for those residents whose families are unavailable to transport and/or accompany them to appointments and to provide the provider with appropriate information.